BUSINESS

OF LIFE STYLE MEDICINE

Joe Raphael, DrPH, FACLM, MBA, LMFT

Applying the Business of Lifestyle Medicine

Abstract: *Lifestyle medicine improves health outcomes by educating and equipping evidence-based interventions to treat and prevent non-communicable disease. The Business of Lifestyle Medicine offers tools and a framework that enables organizations, corporations, healthcare systems, and providers to operationalize the practice of Lifestyle Medicine. The Business of Lifestyle Medicine is the application of an intensive induction phase, followed by tapered consolidation and ongoing sustainability utilizing risk stratification and often demonstrating cost-savings. The purpose of this article was to outline some of my experiences with the Business of Lifestyle Medicine, highlight pivotal considerations when creating a Lifestyle Medicine practice, and illustrate a Lifestyle as Medicine Business Model.*

Keywords: reimbursement; business; lifestyle medicine; public health

In 2007, Dr James Rippe wrote, “A Forum, a Vision, and a Mandate.”¹ Providers who support lifestyle medicine (LM) embrace this mantra and carry forth the directive to

prevent, arrest, and reverse noncommunicable diseases. However, it is the business of lifestyle medicine (BLM) that speaks to organizations, corporations, and health care systems. For LM to succeed, the passion to practice LM must be connected to a sustainable business plan.

In this article, I will provide a brief background detailing my path to LM,

personal trainer, educator, clinician, director, executive, speaker, consultant, and entrepreneur.

As far back as I can remember, LM was what I practiced professionally; it was just not referred to as LM. LM fueled my strategic plan, vision, and mission. I never thought I would need to synthesize my business experiences selling bicycles and teaching creativity

For LM [lifestyle medicine] to succeed, the passion to practice LM must be connected to a sustainable business plan.

some of my experiences with the BLM, a few pivotal questions to consider when creating an LM practice, and a blueprint utilized by LM practices that I helped create.

My Path to Lifestyle Medicine

I have experienced the principles of LM in a multitude of ways: as a patient trying to improve my personal health, as a college athlete who focused on performance, as a student, and as a clinician treating patients. I have been a

to be successful in LM. My reality was that the BLM required far more than what I learned in school.

My Experiences in the Business of Lifestyle Medicine

I entered the BLM as a clinician turned entrepreneur. I provided evidence-based LM programs to physician practices. When I first started 15 years ago, it would take 2 months to convince and educate physicians of the value that LM could offer them. We would then set up

DOI: 10.1177/1559827617691492. Address correspondence to: Joe Raphael, DrPH, FACLM, MBA, LMFT, 15431 SE 82nd Drive, Clackamas, OR 97015; e-mail: Joe.raaphael@wellspring.com.

For reprints and permissions queries, please visit SAGE's Web site at <http://www.sagepub.com/journalsPermissions.nav>.

Copyright © 2017 The Author(s)

multidisciplinary programs lasting 4, 8, or 12 weeks.

We did not charge patients when I started. I was more concerned about whether the patient would attend the appointment. I created incentives—if they attended every session for a minimum of 4 consecutive weeks, then the 4 weeks were free of charge. If they did not attend every session within the 4-week period, patients were charged \$25 per class. Patients would typically come twice per week, and each program covered nutrition, behavior change, and exercise. I developed programs tailored to cardiology, gastroenterology, sports medicine, nutrition, psychology, and psychiatry. We averaged 90% patient retention.

I then focused on engagement outside the physician office. I partnered with plant-based chefs to develop weekly cooking classes. I also held “walk with a doctor” sessions throughout the week. Everything would be done to accommodate patient schedules, including appointments outside of traditional office hours. Payment was \$10 to \$50 (cash) per class or discounted when purchased in 4-week packages. However, no patient was turned away due to financial burden.

I was able to see patients one to one, facilitate groups and classes, and develop the aforementioned programs for approximately 3 years. I spent the next 10 years in health care administration learning about the continuum of care, building partnerships, enhancing operational effectiveness and data utilization to foster bidirectional communication between providers and patients. Yet I was missing the big picture. Regardless of the system of care, location of service, mission/vision, or business plan, one consistent challenge that I faced was how to be appropriately reimbursed for the services provided. It was very clear that reimbursement systems were the drivers of practice models. The question was which model was the “gold standard?”

Business Models

In my experiences developing LM practices, there has not been a single

“gold standard” practice, but common themes do exist. There are a variety of different structures that practices utilize, including different staff models, group models, network models, subscription models, hybrid models, fee-for-care models, and bundled models for target individuals and populations. Many of the models prioritized how to receive reimbursement versus utilizing proven published tools. When I started, most practice owners communicated an interest in fee-for-service. Today, most have an interest in fee-for-service, but are preparing to transition to hybrid models. Regardless of the model, each model focused on risk identification, risk stratification, and cost savings. Virtually all wellness organizations, corporations, and health plans collect and analyze economic data such as absenteeism, presenteeism, and productivity to better understand the role that health plays in reducing costs and maximizing profit.

Creating Your Lifestyle Medicine Practice: Pivotal Questions

The concluding section of this article will highlight pivotal questions followed by an example of an LM practice I helped create. Over the past 15 years, I have asked and been asked many questions regarding the financial aspects of LM. While the questions below are far from a thorough evaluation, I propose they are critical questions to consider before one transitions to an LM practice. A thorough Practice Road Map is needed to truly evaluate resources, relationships, channels, and revenue streams in order to map key action steps.

1. The most common question that is asked: How do I get reimbursed for providing LM services? The answer depends on how you identify the services and provider, especially when insurance is the payer.
 - a. Are you going to bill insurance (ie, traditional fee-for-service)?
 - i. Which CPT codes will you utilize?
 - ii. When do you change units?

- iii. What reimbursement rate per code are you anticipating?
 - iv. Is billing diagnostic specific?
 - b. Do you want to have a monthly subscription fee (ie, direct primary care)?
 - c. Do you have a bundled model?
 - i. Is your model sensitive to your target audience?
 - d. Do you have a hybrid model?
 - i. When will you transition from your current model?
 - e. Do you want to be a cash-only practice?
 - i. Will you accept financing?
 - ii. Where will you position your pricing?
 - f. Should the physician provide all of the services?
 - i. What are the pros/cons of the different types of providers?
 - g. Are the providers credentialed?
 - h. What service(s) are they providing?
 - i. Assessments, Groups, one to one, Specialty Testing?
2. The most common question people forget to ask: Why do I want to provide LM services?
 - a. What is your ideal role?
 - b. What is your personal Mission, Vision, and Strategic Plan?
 - c. What is your business Mission, Vision, and Strategic Plan?
 3. Arguably, the most important question one should ask: How do you define success?
 - a. Does Success = Clinical outcomes?
 - b. Does Success = A Financial Amount?
 - c. Does Success = Leading Others?
 - d. Does Success = Playing a Role in Transitioning Health care?

LM Practice Example

The future of the BLM must move beyond what various individual providers are doing to get reimbursed and focus on reproducible models that can be widely shared. I propose that the BLM review the evidence and bring every provider to that standard. Below are the BLM standards I have observed, experienced, and implemented in over 20 successful LM practices.

Standard LM practices generally include an intensive induction phase, followed by a tapered consolidation and ongoing maintenance. The focus is on sustainable change. Although there were a few physician-only practices who referred patients to outside providers (ie, dietitian, personal trainer, etc), the overwhelming majority of the LM clinics that I worked with employed a combination of fee-for-service, bundled, subscription, or concierge reimbursement models. Most of the practices that I worked with were multidisciplinary teams composed of a physician (MD/DO), doctoral trained (PhD/PsyD/DrPH) professional, registered dietitian (RD), and ancillary staff. Some of the practices also utilized exercise physiologists, personal trainers, plant-based chefs, and coaches. Physical space varied from 400 to 2000 square feet. More square footage allowed additional services like fitness centers, cooking kitchens, or group session space.

Intensive Induction Phase

An intensive induction phase was standard in all of these practices. This was true regardless of the reimbursement model used, patient demographics, or geographical location of the practice. The induction phase always included an initial comprehensive assessment. While providers and reimbursement models varied, the service content did not. Each practice included nutrition, exercise, and behavioral services that were integrated alongside a specialty within medicine. Every practice was initially fee-for-service. However, over time the reimbursement models generally shifted toward more hybrid models. The transition to new reimbursement schemes can be complex and is beyond the scope of this article.

Prior to the initial patient-provider face-to-face encounter, an LM-specific history, intake, HIPPA, and informed consent form were completed online. Patients were encouraged to send all of their medical records to the clinic prior to their appointment. First patient visits lasted 75 to 120 minutes. A medical doctor (MD/DO), registered nurse (RN), and personal trainer conducted the initial

session. The RN gathered vital signs (ie, blood pressure, body fat, basal metabolic rate, and body mass index) and took a brief LM-specific history. The physician encounter lasted 45 to 60 minutes and included exercise clearance and discussion of a few nutrition and behavioral objectives to be accomplished within the next 2 days. Last, the physician would introduce the patient to the personal trainer to discuss exercise experience and goals. Before the patient left, they would be scheduled for a physician follow-up in 2 weeks to review labs, adjust medications if needed, and lay out the next 4-week segment of the treatment plan. Physician visits occurred 2 weeks after the first visit and were generally scheduled every 4 weeks thereafter, or as needed.

Two days after the initial visit, the patient would be scheduled for a second personal training session that occurred after meeting with the RD. The RD saw the patient 2 times per month. During the second week, the patient would have a brief follow-up with the physician before being introduced to the licensed behavioral provider. The licensed behavioral provider saw patients once a week for 6 weeks. A monthly calendar was provided to the patients to help them coordinate all appointments.

Tapered Consolidation and Maintenance

Concurrently modifying multiple behaviors (ie, diet, physical activity, etc) can be complex. Thus, it is important to employ licensed mental health providers who have assessment tools and experience developing intensive treatment plans that focus on sustainability. The behavioral providers typically utilized short-term cognitive behavioral therapy that emphasized positive psychology. Supervised coaching staff provided weekly check-in phone calls that focused on maintenance. There was a strong emphasis on team communication and patient engagement. All staff offered ongoing educational classes throughout consolidation and maintenance phases.

Reimbursement

The physician, RD, and licensed behavioral provider sessions were billed to Preferred Provider Organization insurance. The first 2 personal training sessions were free of charge and the subsequent visits cost \$10 per class. Each class included 3 to 5 members. Individual sessions were available for an additional fee. Coaching and classes were offered on a sliding scale membership model. Pricing was structured to be affordable and was often covered in a membership model.

Conclusion

For the BLM to transform organizations and change how health care is delivered, the weaknesses within the BLM must be addressed. These include a lack of recognition of the economic value of LM, the return-on-investment potential that LM provides, the inherent complexity in creating a true LM practice, and the lack of discrete, easily measureable deliverables (ie, no procedure or pill) that can be billed to patients and insurance companies. The BLM must find solutions that incentivize LM practices and create more opportunities to deliver LM to the patients who need it most.

As reimbursement models shift to focus on patient outcomes, new research supporting the efficacy of LM delivery is conducted, and innovative business practices that ensure appropriate reimbursement for LM services are adopted. LM is positioned to be the future foundation of health care. By focusing on disease prevention and inexpensive treatment options (eg, lifestyle behaviors), LM can be the most cost-effective investment for all payers.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article. [AJLM](#)

Reference

1. Rippe J, Angelopoulos TJ. A forum, a vision, and a mandate. *Am J Lifestyle Med*. 2007;1(1):7-9. doi:10.1177/1559827606295219.